

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2013
FORM APPROVED
OMB NO. 0938-0391

45th 5/18/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445111	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2013
NAME OF PROVIDER OR SUPPLIER HEALTH CENTER AT STANDIFER PLACE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2626 WALKER RD CHATTANOOGA, TN 37421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 272 SS=D	<p>A recertification survey and complaint investigation #30787 and #31114, were completed on April 3, 2013, at The Health Center At Standifer Place. No deficiencies were cited related to complaint investigation #30787 and #31114, under 42 CFR PART 483, Requirements for Long Term Care Facilities.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding</p>	F 272	<p><u>Tag: F272</u></p> <ol style="list-style-type: none"> 1. Resident #8 comprehensive MDS Assessment was unlocked and corrected to reflect accurate coding of section LO200 on 4/8/13. 2. The MDS Nurse Team surveyed all patients who have a similar risk potential. The MDS team determined that this was an isolated coding error involving one MDS Nurse. This survey was conducted during week of 4/8 - 4/12, 2013. The MDS Coordinator will review the Dental section LO200 of each assessment prior to locking and transmitting. If an MDS is found to be miscoded then the MDS Nurse responsible for coding will be notified to correct the MDS. If the MDS has been locked then the assessment will be unlocked and corrected according to proper procedure. 3. The Facility will conduct an in-service during the weeks of 4/22/13 - 5/1/13 regarding "Accurately Coding MDS Dental Section LO200". This in-service will be conducted by the MDS Coordinator for the MDS Nursing Assessment Team. 4. The facility will conduct a quarterly Quality Assurance/Improvement study on "Accurately Coding MDS Dental Section LO200". This study will be conducted by the Assistant DON during our quarterly "In Search of Excellence" QIS floor audits. Ten residents MDS assessments will be audited on each unit for properly coding Dental Section LO200. The MDS Coordinator and Head Nurses receive the results of the floor audit within days of completion. Reporting results of quarterly audit to QA/I committee will 	<p>4/8/13</p> <p>4/12/13 & Ongoing</p> <p>5/1/13</p> <p>Quarterly & Ongoing</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Strawn

TITLE

Administrator

(X6) DATE

4-17-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

APR 17 2013

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F 272	<p>Continued From page 1</p> <p>the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and medical record review, the facility failed to accurately assess the dental status for one (#8) of forty-one residents sampled.</p> <p>The findings included:</p> <p>Resident #8 was admitted to the facility on October 24, 1996, with diagnoses including Schizophrenia, Depression, and Convulsions.</p> <p>Observation and Interview with resident #8 confirmed, on April 1, 2013, at 3:57 p.m., in the resident's room, revealed the resident had missing and broken teeth. Further interview confirmed the resident had no difficulty with chewing or eating and had no complaints of mouth pain.</p> <p>Observation on April 3, 2013, from 8:45 - 9:15 a.m., in the resident's room, revealed the resident self feeding a biscuit, bacon, potato wedges, and beverages. Further observations revealed the intake was greater than 25% (percent) during that time frame.</p>	F 272	<p>occur at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant DON, Dietician, Rehab Director, Food Service Director, Risk Manager, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.</p>		

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F 272	Continued From page 2 Medical record review of the Nutritional Assessment Report signed by the Registered Dietitian, on August 9, 2012, revealed the resident had chewing problems and broken, loose, carious teeth. Review of the Annual Minimum Data Set (MDS) dated August 8, 2012, revealed the resident had no dental issues. Interview with Certified Nurse Aide #1 on April 3, 2013, at 9:05 a.m., at the East 2 nursing station, confirmed the resident had missing and broken teeth. Further interview revealed the resident had no problems eating or chewing and had not complained of mouth pain. Further interview revealed the resident usually ate 25-50% of meals and got a supplement if ate less than 50% of the meal. Interview with Licensed Practical Nurse #3, a MDS Coordinator, on April 3, 2013, at 9:21 a.m., at the East 2 nursing station, revealed the resident had refused to allow an oral inspection at the time of the Annual MDS dated August 8, 2012. Further interview confirmed the oral status section of the MDS included the option of "...G. Unable to examine..." Further interview confirmed the MDS failed to accurately assess the dental status of the resident.	F 272	<u>Tag: F279</u> 1. Resident #455 was in hospital at the time the surveyors entered facility. The resident chose Hospice while in hospital and expired prior to returning to facility. 2. The Head Nurses will audit all resident's Care Plans who have behavioral symptoms to determine if current care plan is updated with measurable goals and appropriate interventions for resident's behavior/s. Care Plans will be updated as necessary during audit. The Head Nurses will conduct this audit during the week of April 15 - 19, 2013. 3. The Facility will conduct an in-service during the weeks of 4/22/13 - 5/1/13 regarding "Keeping Care Plans Updated with Interventions for Current Behavioral Symptoms". This in-service will be conducted by the Staff Development Coordinator and ADON or Designee for Licensed Nurses. 4. The facility will conduct a quarterly Quality Assurance/Improvement study on "Keeping Care Plans Updated with Goals and Appropriate Intervention for Current Behavioral Symptoms". This study will be conducted by the Assistant DON or her Designee during our quarterly "In Search of Excellence" QIS floor audits. All residents (up to a maximum 10 residents) Care Plans will be audited on each unit for suitable problem, measurable goals and appropriate interventions for resident's behavioral symptoms. Head Nurses receive the results of the floor audit within days of completion. Reporting results of quarterly audit to QA/I committee will occur at the next QA/I committee.	4/1/13 4/19/13 5/1/13 Quarterly & Ongoing	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279			

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F 279	<p>Continued From page 3</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide an accurate care plan for one resident, (#455), of forty-one residents reviewed.</p> <p>The findings included:</p> <p>Resident #455 was admitted to the facility on November 15, 2012, with diagnoses including Dementia, Altered Mental Status, Hypertension, Coronary Artery Disease, Atrial Fibrillation, Muscle Weakness, Hypothyroidism, and Encephalopathy.</p> <p>Medical record review of the nurses notes dated January 12, 2013, at Midnight revealed "...refused BP (blood pressure), hitting at nurse, physically aggressive..."; at 11:05 a.m., on January 12,</p>	F 279	<p>following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant DON, Dietician, Rehab Director, Food Service Director, Risk Manager, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.</p>		

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F 279	Continued From page 4 2013, "...very combative /c (with) care, also striking out at nurse trying to ck (check) O2 (oxygen) sat (saturation level) and giving txs (treatments)..."; at 1:35 p.m., on January 12, 2013, "...jerked it out and threw it at writer ..."; at 10:15 a.m., January 13, 2013, "...combative when writer tried to ck (check)...O2 sat (oxygen saturation level)...taking off finger and throwing it..." Medical record review of the care plan dated March 7, 2013, revealed no care planning for behaviors. The care plan dated March 7, 2013, revealed a care plan for "...risk for adverse effects and drug interactions d/t (due to) use of multiple medication and/or psychotropic medications d/t dementia and depression ...patient wanders at night, staff has to redirect patient back to bed...nursing to administer medications as ordered...Ativan 0.5mg po (by mouth) q8h (every 8 hours) prn (as needed) agitation/anxiety..." Interview with Nurse Manager (NM) #2, on April 3, 2013, at 10:00 a.m., in the NM office, revealed the care plan for "...risk for adverse effects and drug interactions ..." was the care plan for the behaviors. Further interview confirmed the combative behaviors were not specifically addressed on the care plan.	F 279	Tag: F281 1. The IV bag hanging in Room 353, observed during initial tour was not connected to the resident and was removed immediately. 2. This was an isolated incident. All other IV's were surveyed and all were labeled correctly per facility policy. The facility will continue to provide and arrange services that meet professional standards of quality as related to IV administration according to Physician's orders and facility policy. Facility policy states that IV bags will be labeled with initial, date and time of initiation of treatment. The procedure and policy for IV administration will be monitored through observation of care rounds conducted by the Head Nurses, Supervisors, ADON, and DON. 3. The Facility will conduct an in-service with Licensed Nurses during the weeks of 4/22/13 – 5/1/13 regarding "Professional Standards of Practice Related to IV Administration, Labeling and Documentation. This in-service will be conducted by the Staff Development Coordinator and ADON or Designee. 4. The facility will conduct a quarterly Quality Assurance/Improvement study related to Professional Standards of Practice for IV administration and labeling. This study will be conducted during our quarterly "In Search of Excellence" on each unit. All residents who are receiving IV fluids or medication will be surveyed for proper labeling. IV should be labeled with initials, date and time on initiation of treatment. Audits will be conducted by the ADON, selected	4/1/13 4/12/13 & Ongoing 5/1/13	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		Quarterly & Ongoing	

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F 281	<p>Continued From page 5</p> <p>Based on observation, review of facility policy, and interview, the facility failed to follow professional standards of practice and facility policy for labeling and dating intravenous (IV) fluid bag and administration set tubing for one resident.</p> <p>The findings included:</p> <p>Observation during initial tour on April 1, 2013, at 11:00 a.m., in resident room number 353, revealed an Intravenous bag of Sodium Chloride 0.9 percent hanging on an Intravenous (IV) pole with administration set tubing attached to the bag, but not the resident. Continued observation, at that time, revealed the IV bag of fluid and the IV administration set tubing were not labeled or dated.</p> <p>Review of facility policy titled "Intravenous Therapy" revealed "...Administration sets will be labeled with initials, date, and time initiated..." Further review of facility policy revealed "...IV fluid bags are changed at least every 24 hours or as indicated..."</p> <p>Interview with Registered Nurse (RN #1) on April 1, 2013, at 11:05 a.m., in the resident's room, confirmed the IV fluid bag and the IV administration set tubing were not labeled or dated. Continued interview with RN #1, at that time, confirmed the RN had not followed facility policy regarding the labeling and dating of IV fluids and administration set tubing.</p>	F 281	<p>Head Nurses, Falls Prevention Nurse/Coordinator and the MDS Coordinator. Reporting results of this quarterly audit to QA/I committee will occur at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant DON, Dietician, Rehab Director, Food Service Director, Risk Manager, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.</p>		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a safe environment on two halls of seven halls in the Hamilton building.</p> <p>The findings included:</p> <p>Observation of the facility on the initial tour April 1, 2013, at 10:50 a.m., revealed on the 900 hall an entrance to the staff lounge and through the staff lounge an entrance to the clean linen closet with the door standing wide open. The clean linen closet door inside the room was unlocked and shut. Observation revealed several personal items of employees, including purses and backpacks, in the staff lounge that were unsecured and accessible to wandering residents. Continued observation revealed one resident sitting in a wheelchair, in the hallway outside the open door. Licensed Practical Nurse (LPN) #2, confirmed the staff lounge door is to be shut and locked because "do have wanderers" on the hall.</p> <p>Repeat observation of 900 hall staff lounge/clean linen closet on April 2, 2013, at 11:00 a.m., revealed the door was shut and locked.</p> <p>Observation of the facility on the initial tour April</p>	F 323	<p><u>Tag: F323</u></p> <ol style="list-style-type: none"> 1. The clean utility/supply room door failing to positively latch, where chemicals and razors were found during surveyor's initial tour was repaired by maintenance prior to end of survey. The Maintenance department had made several attempts during the survey to fix the door closure and locking mechanism, each time adjusting closure and lock, testing door and each time thinking it was corrected. The employee lounge door that was found open was closed immediately, during initial tour. 2. The Head Nurses, Assistant Director of Nursing and Maintenance surveyed all similar risk potential areas where chemicals and/or razors are stored for positively latching doors. These areas included: clean utility rooms, central supply rooms, housekeeping closets and Biohazard Storage rooms on each unit. All doors surveyed were found to be positively latching properly. This survey was conducted during week of April 8 - 12, 2013. Continuous monitoring will also be conducted during observation of care rounds made daily by Head Nurses, Charge Nurses, Supervisors, Nursing Administration and/or Administration. Any door failing to positively latch will be reported to Maintenance Department immediately. All chemicals, razors or any other potentially dangerous material will be removed from room and secured elsewhere until door can be repaired. 3. The Facility will conduct an in-service during the weeks of 4/22/13 - 5/1/13 regarding "Proper Storage of Chemicals and Hazardous Equipment". This in-service will be conducted by the Staff 	4/3/13	4/12/13 & Ongoing
				5/1/13	

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F 323	<p>Continued From page 7</p> <p>1, 2013, at 11:15 a.m., revealed the door to the Treatment Room in the 800 hall was unlocked and the door pushed open very easily. Observation inside the room revealed nineteen 4.5 ounce bottles of Lantiseptic skin protector, seven 8 ounce bottles of aloe vista skin protector, thirty-five bottles of Get Fresh liquid, eight packages of ten-pack single blade razors.</p> <p>Interview with Nurse Manager (NM) # 1, April 1, 2013, at 11:34 a.m., in the hallway outside the treatment room, confirmed the door was unlocked and items labeled "Keep out of reach of children" were present and accessible in the room. Continued interview with NM #1 confirmed the door was to be locked.</p> <p>Repeat observation on April 3, 2013, at 12:15 p.m., revealed the door to the Treatment Room on the 800 hall had a hand written sign "make sure door latches." Observation revealed the door was unlocked, and easily opened.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on April 3, 2013, at 12:18 p.m., in the 800 hall outside the treatment room confirmed the treatment room was unlocked and accessible. Continued interview with LPN #1 confirmed the door was to be locked.</p>	F 323	<p>Development Coordinator and ADON for facility partners.</p> <p>4. The facility will conduct a quarterly Quality Assurance/Improvement study on "Proper Storage of Chemicals and Hazardous equipment". This study will be conducted by the ADON/Risk Manager or designee during our quarterly 3In Search of Excellence" QIS floor audits. All doors leading into areas where chemicals, razors or any other potentially dangerous material will be surveyed to determine that the door is positively latching. Maintenance will be notified immediately if door is found not to be working properly. Head nurses receive the results of the floor audit within days of completion. Reporting results of quarterly audit to QA/I committee will occur at the next QA/I committee following the end of the quarter. The QA/I committee is composed of Administrators, Medical Director, Director of Nursing, Assistant DON, Dietician, Rehab Director, Food Service Director, Risk Manager, Housekeeping Director, Central Supply Director, Laundry Director, Bookkeeping Director and other staff invited to observe and participate.</p>	Quarterly & Ongoing	